Blue Choice® New England
Plan 2 $100 Deductible

Plan-Year Deductible: $100/$300

City of Fitchburg

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes® or Google Play™.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.
Your Care

Your Primary Care Provider (PCP)
When you enroll in this health plan, you choose a primary care provider (PCP) for you and each member of your family. There are a few ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor; consult the Provider Directory; or call the Member Service number on your ID card. If you have trouble choosing a doctor, Member Service can help. They can give you the doctor’s gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist who is likely affiliated with your PCP’s hospital or medical group. Your provider may also work with Blue Cross Blue Shield of Massachusetts regarding Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

When You Choose to Receive Care on Your Own (Self-Referred)
Your health care plan also allows you to seek most care without a referral from your primary care provider, at a lower level of coverage. When you choose to seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call us before you’re admitted to make sure that you’re covered.

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductibles are $100 per member (or $300 per family) for PCP/plan-approved services and $250 per member (or $500 per family) for self-referred services. Your PCP/plan-approved deductible does not count toward your self-referred deductible.

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is $1,500 per member (or $3,000 per family) for PCP/plan-approved and self-referred services combined.

Emergency Room Services
In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Service Area

When Outside the Service Area
If you’re traveling outside the plan’s service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent Benefits
This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.
### Your Medical Benefits

#### Covered Services

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care visits</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)</td>
<td>All charges beyond the maximum, no deductible</td>
<td>20% coinsurance after deductible and all charges beyond the maximum*</td>
</tr>
<tr>
<td>Routine vision exams (one every 24 months)</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Family planning services—office visits</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

#### Outpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$100 per visit, no deductible (waived if admitted or for observation stay)</td>
<td>$100 per visit, no deductible (waived if admitted or for observation stay)</td>
</tr>
<tr>
<td>Office or health center visits, when performed by:</td>
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<td></td>
</tr>
<tr>
<td>- Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as a primary care physician</td>
<td>$20 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>- Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</td>
<td>$25 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$20 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Chiropractors' office visits</td>
<td>$25 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Acupuncture visits (up to 12 visits per calendar year)</td>
<td>$25 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year**)</td>
<td>$25 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment—speech therapy</td>
<td>$25 per visit, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>$20 per category per service date after deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Durable medical equipment—such as wheelchairs, crutches, hospital beds</td>
<td>20% coinsurance after deductible***</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td></td>
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<tr>
<td>Surgery and related anesthesia in an office or health center, when performed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care</td>
<td>$20 per visit †, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>- Other covered providers, including a physician assistant or nurse practitioner designated as specialty care</td>
<td>$25 per visit †, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit</td>
<td>$150 per admission after deductible</td>
<td>20% coinsurance after deductible*</td>
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</tbody>
</table>

#### Inpatient Care (including maternity care)

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>$500 per admission after deductible ‡‡</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Mental hospital or substance use facility care (as many days as medically necessary)</td>
<td>$500 per admission, no deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

* In addition to your deductible and coinsurance, you may be responsible for any balance of charges above the allowed charge.
** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
*** Cost share waived for one breast pump per birth.
† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.
‡‡ Deductible waived for mental health admissions.
### Prescription Drug Benefits*

<table>
<thead>
<tr>
<th></th>
<th>Your Cost For PCP/Plan-Approved Benefits**</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
</table>
| At designated retail pharmacies  
(up to a 30-day formulary supply for each prescription or refill) | No deductible  
$15 for Tier 1  
$30 for Tier 2  
$50 for Tier 3 | Not covered |
| Through the designated mail order or designated retail pharmacy  
(up to a 90-day formulary supply for each prescription or refill) | No deductible  
$15 for Tier 1***  
$30 for Tier 2  
$50 for Tier 3 | Not covered |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.com/mail-order-pharmacy.

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### Get the Most from Your Plan
Visit us at bluecrossma.com or call 1-800-932-8323 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

<table>
<thead>
<tr>
<th>Wellness Participation Program</th>
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</tr>
</thead>
</table>
| **Fitness Reimbursement:** a benefit that rewards participation in qualified fitness programs  
This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs.  
(See your benefit description for details.) | $150 per calendar year per policy |
| **Weight Loss Reimbursement:** a benefit that rewards participation in a qualified weight loss program  
This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals.  
(See your benefit description for details.) | $150 per calendar year per policy |

**24/7 Nurse Care Line**—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)  
No additional charge

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### Questions?
For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-932-8323, or visit us online at bluecrossma.com.  
Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at bluecrossma.com/myblue.  

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers’ compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.
Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.
Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Chinese/简体中文: 注意: 如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：711）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/العربية: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الاتصال TTY: 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដែលបានបង្កើននៅក្នុងសំណង់ការប្រឈមដ៏ល្អឥតទំនៀង និង សំណង់ប្រឈមដ៏ល្អឥតទំនៀង គឺ អាចរកបានសបរាយក្នុងការប្រឈមដ៏ល្អឥតទំនៀង (TTY: 711)។


Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).


Greek/αλληλικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).
Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોછો, તો તમારી ભાષાસહાયતા સેવાઓ તમારી મૂળભૂત ઉપલબ્ધ છે. તમારા આઈડિયની સફર પર આપણી સલાહ નંબર પર મેમીર સેવા ને કોલ કરો (TTY: 711).


Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタントサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY：711）。


Lao/ພາສາລາວ: ກໍານາເວົ້າໃຫ້: ຫຼື້ເຈົ້າເວົ້າພາສາລາວໝໍ, ມີການບບັກການຊ່ວຍເຫຼືກຂອງພາສາໄດ້ທຸກໄດ້ໃຫ້ ທ່ອນ. ເໜ່ຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າຍໜ້າายนຫຼາຍ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Dinë k’ehjí yánilít’i’go saad bee yát’i’ éi t’áájíí’é bee niká’a’doowolgo éi ná’ahoot’i’. Dií bee anítahtíííí ninaaltsoos bine’déé’ nóomba biká’ííjíí’ béishe bee hodíílnih (TTY: 711).

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